Initiate Waiver service
Service Modification
Increase units/hours of service
Decrease units/hours of service
Procedure code modification (requires 2 ISARs)
Provider modification (requires 2 ISARs)
End a service

DAY SUPPORT WAIVER

60-Day Assessment
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Do Not Use for MR Waiver

Provider Name _____ Provider Number _____

Name: _____ Start: _____ End: _____
Last, First MI Date Date

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED	WEEKLY / MONTHLY UNITS	OMR USE ONLY
☐ 97537 DS Reg. Int. Center-Based or Non-Center-Based ☐ 97537 U1 DS High Int. Center-Based or Non-Center-Based ☐ H2025 PREVOC Reg. Intensity ☐ H2025 U1 PREVOC High Intensity	_____ Weekly units x 4.6 = _____ Monthly Total 1	
	+	
Enter **Periodic Support** units per month if needed. Do not include in hours/day below. →	_____ Monthly Total	
	=	
Enter **TOTAL** of Periodic Support units + regular units per month. →	_____ Monthly Total 2	

While providing the agreed-upon supports and services, a 60-day assessment must be used to 1) evaluate the individual's needs and interests in the service environment and community settings and 2) develop an annual service plan. Why is this assessment period needed for this individual?

_____
_____
_____

If High Intensity, check which criteria are met:

☐ Requires physical assistance to meet basic personal care needs

☐ Has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals

☐ Requires extensive personal care and/or constant supports to reduce or eliminate behaviors which preclude full participation in programming. [A formal written behavioral objective is required to address behaviors such as self-injury or self-stimulation.]

Check the allowable activities that are included in the ISP.

Record the number of hours per day of the following: ***(for biweekly/varied schedules, draw a line to indicate different weeks)***	**Sun**	**Mon**	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**
Assessment of and assistance with: ☐ participation in a variety of settings and activities ☐ all life skill areas related to the service, including identification of personal preferences ☐ health and safety issues							
Travel with the individual to and from DS/PREVOC program: (record if billing for this time; can be included up to 25% of the total time; to bill for a 3-unit day, a minimum of 7 hrs of other allowable activities is required; does not include training related travel in scheduled activities)							

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

We, the undersigned, assure that the assessment ISP will be followed by the development and implementation of an annual ISP (approved by the individual) by the end of the 60-day period.

_____
Name of Provider Agency Representative (print) Signature Date

In addition to the assurance above, I agree that the assessment plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

DAY SUPPORT WAIVER

CSB Rep/Case Manager (print) Signature Phone No. Fax No. Date